7.3 List of Diagnosis Related Groups

(a) The following are Major Diagnostic Categories (Organ System Approach):

1. Diseases and Disorders of the Nervous System.

2. Diseases and Disorders of the Eye.

3. Diseases and Disorders of the Ear, Nose, Mouth and Throat.

4. Diseases and Disorders of the Respiratory System.

5. Diseases and Disorders of the Circulatory System.

6. Diseases and Disorders of the Digestive System.

7. Diseases and Disorders of the Hepatobiliary System and Pancreas.

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8. Diseases and Disorders of the Musculoskeletal System and Connective Tissue.

9. Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast.

10. Endocrine, Nutritional and Metabolic Diseases and Disorders.

11. Diseases and Disorders of the Kidney and Urinary Tract.

12. Diseases and Disorders of the Male Reproductive System.

13. Diseases and Disorders of the Female Reproductive System.

14. Pregnancy, Childbirth and the Puerperium.

15. Normal Newborns and Other Neonates with Certain Conditions Originating in the Perinatal Period.

16. Diseases and Disorders of Blood and Blood Forming Organs and Immunological Disorders.

17. Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms.

18. Infectious and Parasitic Diseases (Systemic or Unspecified Sites)

19. Mental Diseases and Disorders

20. Alcohol/Drug Use and Alcohol / Drug Induced Organic Mental Disorders.

21. Injuries, Poisonings and Toxic Effects of Drugs.

22. Burns.

23. Factors Influencing Health Status and Other Contacts with Health Services.

24. Human Immunodeficiency Virus (HIV) Infections.

25. Multiple Significant Trauma.

(b) The following are abbreviations used in ICD-9-CM DRG English descriptors in Appendix 1.5:

1. w AGE 70 CC: Patients who are over age 70 and/or have a substantial complication or comorbidity.

2. wO AGE 70 CC: Patients who are age 0-70 and have no substantial complication or comorbidity.

3. w CC: Patients with a substantial complication or comorbidity.

4. wO CC: Patients without a substantial complication or comorbidity.

5. O.R. Procedures: Therapeutic or diagnostic procedures generally performed in a fully equipped operating room (O.R.).

6. URI: Upper Respiratory Infection.

7. AMI: Acute Myocardial Infarction.

8. CHF: Congestive Heart Failure.

9. D&C: Dilation and Curettage.

10. FUO: Fever of Unknown Origin.

11. NEC: Not Elsewhere Classifiable.

GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

8.1 Calculation of the amount of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement to be distributed

(a) The amount of hospital reimbursement for GME and IME to be distributed shall be calculated based on Medicare principles of reimbursement to major teaching hospitals. Major teaching hospitals are defined as those hospitals which had a minimum of 45 intern and resident full-time equivalents (FTEs) in all approved and accredited residencies from the 1993 Medicare first finalized audited cost report.

(b) Medicare principles of reimbursement for GME and IME are as follows:

1. Direct GME is calculated based on Medicaid's share of the major teaching hospitals' intern and resident FTEs multiplied by their specific per resident amounts as reported on the Medicare audited cost report (including subsequent amendments) in Worksheet E-3 Part IV for the year in which payment is being made.

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2. IME is calculated based on Medicare's IME formula. The major teaching hospitals' IME factor, as calculated by the Medicare IME formula, is multiplied by their hospital-specific Medicaid inpatient DRG payments (net of GME and IME) to arrive at the Medicaid IME payment. The components of Medicare's IME formula, IME intern and resident FTEs and maintained beds, are from the audited Medicare cost report (including subsequent amendments) in Worksheet S-3 for the year in which payment is being made.

8.2 Distribution of GME and IME reimbursement

Hospital reimbursement for GME and IME as calculated in 8.1 shall be distributed to all teaching hospitals based on the hospital-specific percentage of total weighted GME FTEs, where weighted GME FTEs equals the hospital-specific current GME FTEs times the hospital-specific Medicaid fee-for-service days divided by the total Medicaid fee-for-services days for all teaching hospitals. The source for the GME FTEs and the Medicaid fee-for-service days is the Medicare audited cost report including subsequent amendments for the year in which payment is being made.

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8.3 Establishment of GME and IME interim method of reimbursement

Effective for services on or after January 21, 1997, all teaching hospitals are required to submit for the year in which payment shall be made, their estimated average intern and resident GME and IME FTE count and maintained beds by November 1 of the preceding year to Blue Cross and Blue Shield of New Jersey (BCBSNJ), the Division's settlement agent. BCBSNJ shall review the submitted information for reasonableness and consistency and forward the information to the Division. Effective for services on or after October 1, 1996, the Division shall calculate Medicaid's GME and IME payment based on the major teaching hospital's submitted data and their Medicaid inpatient DRG payments (net of IME and GME) from their most current fiscal year fiscal agent settlement data report with twenty-four months of paid data. Once the Medicaid GME and IME payment is calculated, it shall be distributed to all teaching hospitals in accordance with 8.2 utilizing the submitted FTE count and the Medicaid days from the teaching hospitals' most current fiscal year fiscal agent settlement data report with twenty-four months of paid data. The payment shall be made in equal monthly installments and reconciled and in accordance with 8.4.

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8.4 Establishment of GME and IME final method of reimbursement

The Medicaid GME and IME final payment shall be calculated in accordance with 8.1 and distributed to all teaching hospitals in accordance with 8.2. A reconciliation of the final GME and IME distribution of payment to the interim GME and IME distribution of payment shall be made and additional disbursement or recoupment shall be made in accordance with the following:

1. Upon receipt of settlement data, for disbursements, payment shall be made to the hospital for the full amount due within 20 working days.

2. The fiscal agent shall begin recoupment on Medicaid payments for the full amount of the overpayment 30 days after the date the Division reviews BCBSNJ's overpayment notification by withholding the Medicaid payments to the hospital.

3. If the withholding of New Jersey Medicaid payments is not acceptable to the hospital, the hospital must submit, prior to the end of the 30-day period, a proposed repayment schedule to the Division. For a repayment schedule in excess of three months, documentation (as specified in Medicare Bulletin No. 0452) shall be submitted. If an appropriate repayment schedule is not received by the Division, the withholding of Medicaid payments shall be implemented to begin recoupment.

4. Interest shall be charged at the maximum legal rate as of the date of the repayment agreement or 30 days from the date of the BCBSNJ letter to the Division, whichever is sooner.

SUBCHAPTER V REVIEW AND APPEAL OF RATES

9.1 Review and Appeal of Rates

(a) All hospitals within 15 working days of receipt of the Proposed Schedule of Rates, shall notify the Division of any calculation errors in the rate schedule. If upon review it is determined by the Division that there is an error that is substantial, that is greater than $100,000 or 2% of an institution's total revenue, a revised rate will be issued to the hospital.

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(b) Any hospital which seeks an adjustment to its rates must agree to an operational review at the discretion of the Department of Human Services.

1. A request for a rate review must be submitted by a hospital in writing to the Department of Human Services, Division of Medical Assistance and health Services, Office of Budget, Fiscal Affairs and Information Systems, PO Box 712, Trenton, New Jersey 08625, within 20 days after publication of the rates by the Department of Human Services (DHS).

   i. A hospital shall identify its rate review issues and submit supporting documentation in writing to the Division within 80 calendar days after publication of the rates by the DHS.

2. The Division will not approve an increase in a hospital's rates unless the hospital demonstrates that it would sustain a marginal loss in providing inpatient services to Medicaid recipients at the rates under appeal even if it were an economically and efficiently operated hospital. Any hospital seeking a rate increase must demonstrate the cost it must incur in providing services to Medicaid recipients and the extent to which it was taken all reasonable steps to contain or reduce the costs of providing inpatient hospital services. The hospital may be required at a minimum to submit to the Department of Human Services, the following information: